House of Representatives

General Assembly

File No. 277

January Session, 2009

Substitute House Bill No. 6416

House of Representatives, March 26, 2009

The Committee on Human Services reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) The rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals, providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent **[**, if any,**]** that the commissioner determines a hospital to be a disproportionate share hospital, in accordance with subsection (b) of this section, and that a greater amount is appropriate. **[**in the case of hospitals serving a disproportionate share of indigent patients.**]** Such rate shall be

promulgated annually by the Commissioner of Social Services. Nothing contained in this section shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public. Notwithstanding the provisions of this section, for the rate period beginning July 1, 2000, rates paid to freestanding chronic disease hospitals and freestanding psychiatric hospitals shall be increased by three per cent. For the rate period beginning July 1, 2001, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two and one-half per cent more than the rate it received in the prior fiscal year and such rate shall remain effective until December 31, 2002. Effective January 1, 2003, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year. Notwithstanding the provisions of this subsection, for the period commencing July 1, 2001, and ending June 30, 2003, the commissioner may pay an additional total of no more than three hundred thousand dollars annually for services provided to long-term ventilator patients. For purposes of this subsection, "long-term ventilator patient" means any patient at a freestanding chronic disease hospital on a ventilator for a total of sixty days or more in any consecutive twelve-month period. Effective July 1, 2007, each freestanding chronic disease hospital shall receive a rate that is four per cent more than the rate it received in the prior fiscal year.

(b) In determining the rate paid by the state to a hospital, the commissioner shall consider whether the hospital is a disproportionate share hospital. For purposes of this section, "disproportionate share hospital" means a hospital that has (1) a Medicaid inpatient utilization rate of at least the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or (2) a low-income utilization rate exceeding twenty-five per cent. The terms "Medicaid inpatient utilization rate" and "low-income utilization rate" have the same meanings as such terms in Section 1923 of Title XIX of the federal Social Security Act, 42 USC 1396r-4, as amended from time to time. The commissioner shall establish a rate for such a hospital that

appropriately reflects its status as a disproportionate share hospital.

(c) Not later than January 1, 2010, the commissioner shall review and adjust the rates of all disproportionate share hospitals, as the commissioner deems appropriate.

[(b)**]** (d) Effective October 1, 1991, the rate to be paid by the state for the cost of special services rendered by such hospitals shall be established annually by the commissioner for each such hospital based on the reasonable cost to each hospital of such services furnished to state patients. Nothing contained herein shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

[(c)**]** (e) The term "reasonable cost" as used in this section means the cost of care furnished such patients by an efficient and economically operated facility, computed in accordance with accepted principles of hospital cost reimbursement. The commissioner may adjust the rate of payment established under the provisions of this section for the year during which services are furnished to reflect fluctuations in hospital costs. Such adjustment may be made prospectively to cover anticipated fluctuations or may be made retroactive to any date subsequent to the date of the initial rate determination for such year or in such other manner as may be determined by the commissioner. In determining "reasonable cost" the commissioner may give due consideration to allowances for fully or partially unpaid bills, reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators, requirements for working capital and cost of development of new services, including additions to and replacement of facilities and equipment. The commissioner shall not give consideration to amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose

unionization. Nothing in this subsection shall prohibit the commissioner from considering amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations.

[(d)**]** (f) The state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services. The emergency room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained herein shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios in effect June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995. Except with respect to the rate periods beginning July 1, 1999, and July 1, 2000, such fee schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial

tomography. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies, identifying such fee increases and the associated cost increase estimates.

[(e)**]** (g) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing contained in this subsection or the regulations adopted hereunder shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public.

[(f)**]** (h) On and after October 1, 1984, the state shall pay to an acute care general hospital for the inpatient care of a patient who no longer requires acute care a rate determined by the following schedule: For the first seven days following certification that the patient no longer requires acute care the state shall pay the hospital at a rate of fifty per cent of the hospital's actual cost; for the second seven-day period following certification that the patient no longer requires acute care the state shall pay seventy-five per cent of the hospital's actual cost; for the third seven-day period following certification that the patient no longer requires acute care and for any period of time thereafter, the state shall pay the hospital at a rate of one hundred per cent of the hospital's actual cost. On and after July 1, 1995, no payment shall be made by the state to an acute care general hospital for the inpatient care of a patient who no longer requires acute care and is eligible for Medicare unless the hospital does not obtain reimbursement from Medicare for that stay.

[(g)**]** (i) Effective June 1, 2001, the commissioner shall establish inpatient hospital rates in accordance with the method specified in

regulations adopted pursuant to this section and applied for the rate period beginning October 1, 2000, except that the commissioner shall update each hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half per cent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's rate is increased pursuant to this subsection, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. For rate periods beginning October 1, 2001, through September 30, 2006, the commissioner shall not apply an annual adjustment factor to the target amount per discharge. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective October 1, 2007, the commissioner, in consultation with the Secretary of the Office of Policy and Management, shall establish, within available appropriations, an increased target amount per discharge of not less than four thousand two hundred fifty dollars for each hospital with a target amount per discharge less than four thousand two hundred fifty dollars for the rate period ending September 30, 2007, and the commissioner may apply an annual adjustment factor to the target amount per discharge for hospitals that are not increased as a result of this adjustment. Not later than October 1, 2008, the commissioner shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies identifying any increased target amount per discharge established or annual adjustment factor applied on or after October 1, 2006, and the associated cost increase estimates related to such actions.

Sec. 2. Subsection (b) of section 17b-263 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(b) The rate paid for hospital outpatient mental health therapy services, except for partial hospitalization and other comprehensive services as defined by the commissioner, shall be that established in subsection **[**(d)**]** (f) of section 17b-239, as amended by this act, for an outpatient clinic visit. Payment for partial hospitalization services shall be considered payment in full for all outpatient mental health services.

Sec. 3. Section 19a-617c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

Payments made to hospitals pursuant to subsection **[**(g)**]** (i) of section 17b-239, as amended by this act, shall include any inpatient service days provided in a new long-term acute care hospital or satellite facility established as a demonstration project pursuant to section 19a-617b. For the purposes of rate setting and cost per discharge settlement pursuant to said subsection **[**(g)**]** (i), the inpatient stay of a patient eligible for medical assistance shall include both short-term and long-term acute care hospital days provided in a new long-term acute care hospital or satellite facility established as a demonstration project pursuant to section 19a-617b. Notwithstanding any provision of the general statutes, a short-term acute care hospital may enter into an agreement with a chronic disease hospital that establishes a new long-term acute care hospital or satellite facility as a demonstration project pursuant to section 19a-617b, to distribute payments received under section 17b-239, as amended by this act, for services provided by such long-term acute care hospital or satellite facility.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	17b-239
Sec. 2	*July 1, 2009*	17b-263(b)
Sec. 3	*July 1, 2009*	19a-617c

Statement of Legislative Commissioners:

In sections 2 and 3, the phrase "as amended by this act" was added after the references to section 17b-239 for accuracy. In section 2, the

reference to subsection (e) was changed to subsection (f) and in section 3, the two references to subsection (h) were changed to subsection (i) for accuracy.

HS *Joint Favorable Subst.-LCO*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 10 $	FY 11 $
Department of Social Services	GF - Cost	$2 million	$4.1 million

Municipal Impact: None

Explanation

This bill changes the Medicaid rate setting methodology related to disproportionate share payments for hospitals. It is estimated that eight additional hospitals would qualify for a disproportionate share adjustment, for an additional annual cost to the state of approximately $4.1 million. This would have a $2 million cost in FY 10 as the bill requires the Department of Social Services to make these rate adjustments by January 1, 2010.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Public testimony, DSS financial reports

OLR Bill Analysis

sHB 6416

AN ACT CONCERNING DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS.

SUMMARY:

This bill changes the formula that the Department of Social Services (DSS) uses to calculate which hospitals receive additional Medicaid reimbursement for serving a disproportionate share of indigent patients. It requires the DSS commissioner, when making this determination, to determine if it is a "disproportionate share hospital" and if so, reflect that status in the rate. By doing so, the bill potentially increases the number of hospitals receiving these additional payments.

The bill requires the commissioner, by January 1, 2010, to review and adjust, as he deems appropriate, the Medicaid rate the state pays to all disproportionate share hospitals. (Although the bill does not specify it, presumably his review and adjustment must be in accordance with the bill's new formula.)

The bill also makes technical, conforming changes.

EFFECTIVE DATE: July 1, 2009

MEDICAID PAYMENTS FOR HOSPITALS

Definitions

The bill defines a disproportionate share hospital as one that (1) has a Medicaid inpatient utilization rate of at least the mean Medicaid inpatient utilization rate for hospitals that receive Medicaid reimbursements or (2) a low-income utilization rate higher than 25%.

The bill specifies that the terms "Medicaid inpatient utilization rate"

and "low-income utilization rate" have the same meaning as under federal law.

Federal law defines the first term as a ratio of the hospital's number of inpatient days attributable to Medicaid-eligible patients to the total number of hospital's inpatient days.

"Low-income utilization rate" is the sum of two ratios. The first is the ratio of the sum of (1) total revenue paid for Medicaid plus the amount of cash subsidies for patient services the hospital receives directly from state or local governments to (2) the total amount of hospital revenue for patient services, including the subsidies, during this period. The second is the ratio of the total amount of the hospital's charges for inpatient services attributable to charity care in a period minus the portion of any cash subsidies in the period reasonably attributable to inpatient services to the total amount of the hospital's charges for inpatient services.

Change in Formula

Under current law, the Medicaid rate DSS pays acute care hospitals is based upon the lowest of the reasonable cost to the hospital or the charge to the general public. But it pays a greater amount, as the commissioner determines, when the hospital serves a disproportionate share of indigent patients (called a DSH payment). A disproportionate share hospital is not defined in state law but it is in federal law.

Currently, hospitals qualify for a DSH adjustment to their Medicaid rate if (1) their Medicaid inpatient utilization rate (for both fee-for-serve and managed care) is at least one standard deviation above the mean state-wide Medicaid inpatient utilization percentage or (2) their low income utilization rate exceeds 25%. The bill requires a DSH adjustment for hospitals that have a Medicaid inpatient utilization rate of at least the mean statewide Medicaid inpatient utilization rate. (Federal law requires states to pay the add-on to any hospital that is at least one standard deviation above the mean but states can go beyond this minimum.) The standard deviation is a statistical measure of the

dispersion of hospital utilization rates around the average. The use of this measure identifies hospitals whose Medicaid utilization is unusually high.

BACKGROUND

Federal Law

Under federal law, to be deemed to be serving a disproportionate share of indigent patients, a hospital must also have at least two obstetricians who have (1) staff privileges at the hospital and (2) agreed to provide obstetric services to Medicaid-eligible women.

COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 15 Nay 3 (03/10/2009)